

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN4203ASC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2008
NAME OF PROVIDER OR SUPPLIER SIERRA VISTA SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10463 DOUBLE R BLVD BLDG 15 RENO, NV 89521		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 00	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a focused State Licensure survey conducted at your facility on 3/5/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Surgical Centers for Ambulatory Patients. Findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies were identified.		A 00		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE